June 13, 2003

Jo Anne Barnhart
Commissioner of Social Security
P.O. Box 17703
Baltimore, MD 21235-7703.

Re: **Revised Medical Criteria for Evaluating Mental Disorders**
Advance Notice of Proposed Rulemaking
68 *Federal Register* 12639, March 17, 2003

UCP
Understanding Disabilities
Creating Opportunities

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Dear Commissioner Barnhart:

On behalf of United Cerebral Palsy Associations, Inc. (UCP), I am pleased to submit the attached comments on the Advance Notice of Proposed Rulemaking for Revised Medical Criteria for Evaluating Mental Disorders, published in the *Federal Register* on March 17, 2003.

For 50 years, UCP has been committed to change and progress for persons with disabilities. The national organization and its nationwide network of 105 affiliates in 37 states strive to ensure the inclusion of persons with disabilities in every facet of society—from the Web to the workplace, from the classroom to the community. As one of the largest health charities in America, UCP's mission is to advance the independence, productivity and full citizenship of people with cerebral palsy and other disabilities, through our commitment to the principles of independence, inclusion and self-determination. Many people with cerebral palsy rely upon SSI and Title II disability benefits.

Attached are two documents. The first document contains UCP's comments (in collaboration with CCD) on the advance notice of proposed rulemaking. The second is an appendix to the comments showing some specific recommendations for changes in the Introduction sections, 12.00 and 112.00.

We appreciate this opportunity to comment on revisions to the mental disorder listing prior to publication of a notice of proposed rulemaking. We applaud your seeking input before publishing an NPRM on an issue of this importance that will affect so many people with disabilities. We also would welcome the opportunity meet with you to discuss our recommendations and to respond to any questions you may have.

If you have any questions, please contact Marty Ford (202-783-2229) or ford@ppcollboration.org at The Arc and UCP Public Policy Collaboration.

Sincerely,

Leon Triest

Leon Triest
Chair, UCP Public Policy Committee

CCD COMMENTS TO ADVANCE NOTICE OF PROPOSED RULEMAKING ON REVISED MEDICAL CRITERIA FOR EVALUATING MENTAL DISORDERS

68 Fed. Reg. 12639 (Mar. 17, 2003)

I. Introduction to Comments

The Consortium for Citizens with Disabilities Task Forces on Social Security and Work Incentives Implementation (hereinafter "CCD") appreciate the opportunity to comment on the Advance Notice of Proposed Rulemaking regarding revised medical criteria for evaluating mental disorders.

CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. The CCD Social Security and Work Incentives Implementation Task Forces focus on disability policy issues in the Title XVI Supplemental Security Income program and the Title II disability programs.

In general, CCD believes that the structure and design of the mental impairment listing works for the purpose of assessing children and adults with mental disorders. The basic structure and approach to the listings were developed by an expert panel appointed by the Social Security Administration prior to the publication of the adult listing in 1985. Based on the adult listing and with significant input from childhood disability experts, SSA published the children's listing in 1990. In fact, many of our member organizations worked extensively with members of the expert panel on recommendations regarding provisions currently in the listings. The structure and approach have stood the test of time and still prove to be practical and workable for the evaluation of adults and children.

CCD believes that there are important updates and refinements that should be included in the listings for adults and children and we make specific recommendations below. These recommendations are for refinements within the current structure of the listing. We do not believe that major overhaul of the mental disorder listing is necessary. However, if SSA contemplates major overhaul of the listing, we urge that SSA formally adopt an expert panel process similar to that used prior to the publication of the adult listing in 1985, to ensure careful consideration of all recommendations for and ramifications of change.

II. Introduction to Mental Disorders Listings: Section 12.00

The Introduction to the Mental Disorders Listings, Section 12.00, provides detailed guidance for all disability adjudicators. As a result, it plays an important role in the decision-making process for individuals with mental impairments, including those whose impairments do not meet a listing. Our comments, as described below, address: (1) inclusion of important SSA policies in the Introduction; and (2) recommendations for policy changes.

We have included proposed language amending section 12.00, which is attached as Appendix A to our comments.

1. Assessment of severity

- **Add "extreme" for measuring degree of limitation**

In SSI childhood disability claims, SSA looks at six different domains to determine functional equivalence to a listed impairment. A child is considered disabled if he or she has "marked" limitations in two domains or an "extreme" limitation in one domain. We recommend that SSA add explicit language that an impairment meets the "B" criteria if there is an "extreme" limitation in one of four "B" criteria, in addition to the current language requiring "marked" limitations" in two of the "B" criteria. See App. A.

- **Better definition of "marked" and "extreme"**

For "marked," we have added language from the SSI childhood disability regulations that include "standardized testing with scores that are at least two, but less than three, standard deviations below the mean." 20 C.F.R. § 416.926a(e)(2). See App. A. It is important to stress that "marked" represents a serious, but less than extreme level of functional limitation. "Marked" should not be interpreted as requiring little or no function, such as being unable to feed and clothe oneself without assistance, or being limited to social interaction with only a few friends or family members.

For "extreme," we have used the definition in the SSI childhood disability regulations. 20 C.F.R. § 416.926a(e)(2). See App. A.

We also recommend that the Introduction mention that other measures of function, including the Global Assessment of Functioning (GAF), frequently found in the diagnostic portion of mental health records, can provide useful evidence of overall, serious functional deficits when adequately documented and can be used as evidence to measure the severity of functional limitations. However, since it is a "global" assessment of function, an overall score that appears above the level of "marked" may, in fact, hide deficits in particular areas that meet the requirements of the listings.

2. Evidence issues

- **The importance of recognizing and properly weighing evidence from all treating sources**

We recommend that SSA provide clear guidance to adjudicators in the Introduction section of the listings and in separate regulations regarding the importance of evidence from all treating nonphysician professionals in assessing the limitations imposed by mental impairments.

The fact that SSA has established a distinction between "medical" and "nonmedical" evidence allows adjudicators to consider nonphysician evidence, even though provided by licensed health

professionals, to be less important. As a result, some adjudicators give this evidence less weight than it deserves, despite the fact that it is the key information needed to establish the individual's functional limitations.

We agree that evidence from an "acceptable medical source" is necessary to establish the existence of a "medically determinable impairment" as required by the Social Security Act. See 20 C.F.R. §§ 404.1513(a) and 416.913(a). However, the regulations go on to say that once a "medically determinable impairment" is established, evidence from "other sources" is obtained to show the severity of the impairment and the limitations it imposes. This creates an artificial distinction between evidence elicited from a particular source. 20 C.F.R. §§ 404.1513(d) and 416.913(d). Evidence from treating sources who are licensed health professionals working under the supervision of a physician should not be treated differently than that given by a psychiatrist or psychologist.

These "other sources" include many of the primary sources of treatment for individuals with mental impairments, e.g., nurse practitioners and physicians' assistants, therapists, psychiatric social workers, and educational personnel. Many individuals with mental illness are seen infrequently by physicians and usually only for a review of medications. Other nonphysician professionals are entrusted with their day to day care and are qualified and trained to recognize, treat, and evaluate mental illness.

Often, adjudicators over-rely on physician evidence. Based on our experience, the nonphysician professional sources often are disregarded or given less weight because they are not physicians, when, in fact, they are the most important source of evidence about individuals with mental impairments.

SSA has recognized that evidence from these "other sources" is crucial to establishing the severity of mental impairments and the limitations they impose. For instance, similar concerns were raised in comments regarding the final rule on mental disorders, 65 Fed. Reg. 50746 (Aug. 21, 2000). In response, SSA noted that, while these nonphysician medical sources are not "acceptable medical sources," "[s]uch sources can, however, provide very valuable information about the severity of an impairment(s) once [a medically determinable impairment] has been established." 65 Fed. Reg. at 50761. However, in creating this dichotomy, SSA has relegated the evidence of such professionals to a catch-all status that is easily dismissed.

Another comment noted that many individuals with mental impairments have no history of being treated for their disorders and that SSA's emphasis on "medical" evidence "tends to reward those who can afford treatment while penalizing poorer individuals." 65 Fed. Reg. at 50763. In sharing these concerns, SSA responded that "we consider all evidence in the case record that is relevant to our assessment of the individual's ability to function. This includes information from both medical and nonmedical sources." *Id.* at 50764. In fact, such evidence is often ignored and individuals are denied because they have not adequately documented their limitations with "medical evidence."

The same concerns were raised in the final rule on SSI childhood disability, 65 Fed. Reg. 54747 (Sept. 11, 2000), where such evidence receives more serious attention. One commenter urged

SSA to consider evidence from social workers, clinical psychologists, and nurse specialists as "valid and appropriate documentation of disability. *Id.* at 54765. Recognizing the importance of these medical sources, SSA responded that "[e]vidence from these other health care professionals helps us understand how a child's impairments affect ability to function." *Id.* They should be treated no differently than other medical sources.

- **Role of nonphysicians and multi-disciplinary concept in treatment**

A recurring problem concerning evaluation of persons who have mental impairments is the treatment of evidence from therapists and other professionals who have the most contact with patients. The organization of and division of labor in community mental health centers is such that an individual patient may see the psychiatrist only once a month to evaluate medications, often for a very brief visit. On the other hand, the people most familiar with the case and the individual claimant's functional limitations are therapists or psychiatric social workers who see the individual on a daily or weekly basis. Current regulations treat evidence from such individuals merely as "other evidence," which creates several problems.

Such evidence is not treated as "medical evidence of record," even though it is prepared by a professional, included in the psychiatric case file and an integral part of a physician supervised treatment team. Indeed, if a psychiatrist were to find the time to write a report for Social Security he or she would certainly rely upon the day-to-day description found in the case file prepared by these professionals. We urge the Social Security Administration to alter its position and treat such information as medical evidence when it comes from a licensed clinic or is part of a medically supervised treatment plan. To do otherwise is to treat low-income claimants unfairly, since it denigrates the evidence of the people who know the patient best, merely because they cannot afford treatment in a setting where most of the work is done by physicians. We are not arguing for special treatment – obviously there will be situations in which the evidence provided is not credited for a variety of reasons, just as evidence from treating psychiatrists is not always given controlling weight. We are only urging treatment that affords such evidence its proper weight. Similar treatment has been afforded in the past to evidence from members of multi-disciplinary team members, even if they were not physicians, as long as the evaluations were part of the team's treatment plan.

Considering such evidence will have several effects. For instance, it will allow the opinions of those who know claimants best to discuss whether the claimant meets the C criteria. See discussion of "C" criteria below in § V.

Second, a similar problem is the failure to afford any special weight to the opinion of therapists and others as to claimant function. Often, the adjudicator will give more weight to consultative examiners who see the claimant only once, and even worse, to nonexamining state agency physicians who only review the file. Indeed, the regulations and other SSA policies seem to reinforce this result. Considering the evidence of a mental health center and all its personnel as medical evidence of a treating source would do much to resolve this unfairness, while still giving SSA the flexibility to make decisions based on the totality of the evidence.

Many of the troubling problems SSA encounters with differential approval rates from state to state and by race may be attributable to the inadvertent bias that has crept into the evaluation process as a result of the failure of the regulations to take into account the different treatment options available to low income people, especially in states and cities where public health facilities are hard pressed and strapped for resources. Recognition of the value of opinions from nonphysicians would help rectify this problem and make for a fairer climate of adjudication.

- **Third-party evidence**

It is not uncommon for some individuals with mental impairments to underestimate the impact of their impairments on their functioning. Sometimes an individual with a mental impairment will discount significant limitations in order to make herself appear more like other people, or to improve how other people relate to her. Under such circumstances, third-party input from persons who live or interact routinely with the claimant is essential.

We recommend that SSA explain in Section 12.00D.1.b that under some circumstances it would be beneficial to obtain a third-party assessment of an adult claimant's functioning. Especially for impairments impacting cognitive abilities, such as traumatic brain injury (TBI) and mental retardation, the claimant may be unable to describe his or her actual limitations; and for some impairments, like personality disorders or obsessive compulsive disorder, the claimant may be averse to revealing any functional limitations. For some claimants with TBI and mental retardation in particular, it may be necessary that SSA examiners interview a reliable third-party to gain independent knowledge of the claimant's impairments prior to making a disability determination.

When a claimant is unable to describe functional limitations, or when the medical evidence suggests more serious functional limitations than are self-reported, it is necessary to make every effort to obtain a description of the claimant's typical functioning from a person who interacts routinely with the claimant to supplement any self-report of functioning. We recommend that SSA make every effort to obtain third-party descriptions of functioning whenever a claimant is unable to describe her limitations, as well as whenever the self-reported functioning surpasses what would be expected from the medical evidence of record.

- **Work and work attempts: Supported work**

We have proposed changes to Section 12.00 regarding supported work settings. Some adjudicators conclude that attendance in a supported work setting means that a claimant with a mental impairment can have no significant limitations in social functioning or in concentration, persistence, and pace merely because the claimant is engaged in work-like activities. Furthermore, when a claimant with autism or one of the autistic spectrum disorders is engaged in supportive work, some adjudicators conclude that the claimant has no "qualitative deficits in reciprocal social interaction" and no "qualitative deficits in verbal and nonverbal communication" merely because the claimant participates in a supported work program. This especially is problematic for redeterminations of 18 year olds who may have been disabled since infancy.

Because there is no vocational assessment involved in the decision-making at the initial and reconsideration levels (and only vocational expert testimony is available at the administrative law judge hearing level), it is apparent that supported work employment may be improperly interpreted to mean that the claimant is not disabled without a full appreciation for the realities of supported work settings. Generally, the need for such a setting for a claimant with a mental impairment would preclude gainful activity in competitive employment. Moreover, should the claimant's impairment not meet or equal listings-level severity, a thorough vocational assessment should lead to a finding of disabled under Step 5 because a claimant in supported work settings usually would be unable to learn to do unskilled work within 30 days.

3. Consideration of drug use as a symptom of another mental impairment

Drug use may be a symptom of another mental impairment. Further, many individuals diagnosed with mental illness also have substance abuse problems. SSA's rules should provide clear guidance to adjudicators that the mere fact of substance abuse is not grounds for denying a claim and that they must distinguish between cause and effect.

The current Introduction does not fully discuss how drug addiction and alcoholism (DAA) is to be evaluated under the Listings. Although the DAA provisions were last changed in 1996, SSA has not changed the listing language, either listing 12.09, which is structured as a reference listing, or to reference the "materiality" regulations, 20 C.F.R. §§ 404.1535 and 416.935. We have proposed language in Appendix A that cross-references SSA's existing rules which require a determination whether drug addiction or alcoholism is a contributing factor material to the determination of disability.

The listing language should reflect the DAA regulations because most medical advisors at ALJ hearings do not have access to the entire set of regulations but instead rely on the SSA publication, "Disability Evaluation Under Social Security," which includes only the listings.

4. Treatment affecting signs and symptoms

For many individuals with mental illness, medication will treat the overt signs and symptoms (such as hallucinations) but not the resulting functional deficits (often termed negative symptoms). This means that some individuals on medication may no longer meet the A criteria regarding signs and symptoms, even though they have a diagnosis of a listed disorder, but nonetheless they meet the B criteria regarding function.

Section 12.00 should clarify that when an individual meets the B criteria with a diagnosis cited in the A criteria, he or she will qualify, just as others do whose overt symptoms are not controlled with medication.

5. Documentation

A discussion about school attendance and vocational training has been added to the Documentation section in the Introduction (Appendix A) to provide needed guidance for evaluating cases of young adults for whom such evidence is particularly relevant.

6. Medical equivalence

For persons who cannot exactly meet any specific A criteria, but who meet the B or C criteria, we have expanded discussion of the "B" and "C" criteria. We urge SSA to make clear that individuals with medically determinable impairments who satisfy either Paragraph B or C criteria are disabled. This establishes a "medical equivalence" standard and such an approach, like the focal point of the mental disorders listings, focuses on the impact of the functional limitations, which are assessed under the B or C criteria.

III. "A" Criteria Issues Regarding Specific Listings

1. "Marked" as a factor in the "A" criteria

We begin with the assumption that the "A" criteria should only deal with the diagnosis, primarily to satisfy the statutory requirement that a person be diagnosed with a physical or mental impairment. The extent to which a particular diagnosed impairment is or is not disabling is largely a function of the B and C criteria. This seems to be the operating assumption SSA has used in constructing the Listings. However, for a number of diagnoses, there are functional requirements that have crept in to the A criteria. Since this is not universal, it gives the impression that the criteria for certain mental impairment diagnoses have a higher threshold of disability, when, as we understand it, the level of dysfunction that leads to a finding of disability should not vary from one diagnosis to another. To make matters worse, these A criteria often use the term "marked" to describe the diagnostic symptoms that are required, adding an additional layer of confusion. Does that mean the same thing as "marked" in the B criteria, and, if so, what does it mean to have a "marked" in the A criteria? Does that mean one needs three marked for particular diagnoses, or does it mean that one already has a "marked" impairment of function that obviates the need to meet two others? Examples of this include:

- 12.06A.3/112.06A.5: "Recurrent *severe* panic attacks manifested by a sudden unpredictable onset of *intense* apprehension ... occurring on the average of *at least once a week.*" With symptoms of this magnitude how could anyone not have "marked" impairments in function? Even panic attacks of less frequency might leave a person with a "marked" inability to perform activities of daily living (ADLs).

- 12.06 A.4/112.06A.6: "Recurrent obsessions or compulsions which are a source of *marked* distress" and 12.06A.5/112.06A.7. "Recurrent and intrusive recollections of a traumatic experience, which are a source of *marked* distress." Both these requirements of "marked" distress confuse the issue and make one wonder if the definition is the same for "marked" in the B criteria. Is it possible to have marked distress and not meet the B criteria for marked in ADLs and social function?

- 12.07/112.07: "Somatoform disorders: Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms." Requiring *no* organic findings is inconsistent with the DSM and unrealistic since many who suffer from this disorder have slight organic findings to which they attach inappropriate significance. In fact

the capsule definition is inconsistent with the criteria in 12.07A.3, which only requires "unrealistic *interpretation* of physical signs."

- 12.07.A.1: "A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and *alter life patterns significantly*." This one subsection contains several problems. First, it is clear in the DSM that not all such disorders require onset before age 30. (Compare 300.81, Somatization Disorder, requiring onset by age 30, with 300.82, Somatoform Disorder, which has no diagnostic onset date.) Second, it is unclear how life patterns could be altered significantly without that having a marked effect on activities of daily living. Third, not all such individuals will take medicine frequently, since their physicians may refuse to prescribe it. Finally, requiring symptoms of several years duration is inconsistent with the Act, if individuals are not allowed to provide evidence that such symptoms are projected to persist for several years. While duration of symptoms may be clinically significant (and even the DSM does not require symptoms to last "several years"), the law simply does not require such a long duration, especially given how vague "several years" is as a standard.

- 12.08: The capsule definition reads: "Personality disorders: A personality disorder exists when personality traits are inflexible and maladaptive and cause either *significant* impairment in social or occupational functioning or subjective distress." This is certainly a higher functional hurdle than for other impairments, since in addition to meeting these capsule requirements, the claimant must also meet the same B criteria as other individuals. In addition, the requirement that "characteristic features are typical of long term functioning and are not limited to discrete episodes of illness" seems inconsistent with B.4 "repeated episodes of decompensation."

- 12.10/112.10: The capsule definition of an Autistic Disorder requires a "*markedly* restricted repertoire of activities and interests," a phrase repeated in A.1.c. Would this not also satisfy a marked restriction in social function? How would this be different than a qualitative deficit in reciprocal social interaction, another A criteria, specifically, 12.09A.2.a?

- 112.03: The children's schizophrenia listing requires a "*marked* disturbance of thinking, feeling, and behavior."

- 112.04: The children's mood disorder listing requires "*markedly* diminished interest or pleasure" at two separate places, the capsule definition and at 112.04 A.1.b.

- 112.11: The children's ADHD listing requires *marked* inattention, impulsiveness, hyperactivity and then refers the adjudicator to the B criteria to make further findings of two more *marked* functional limitations.

- 12.05/112.05: As we discuss more fully in Section VII dealing with mental retardation, see below, the requirement in the capsule section of "deficits in adaptive function," 12.05/112.05, can impose a standard of disability that is unrealistically high. It requires not only a very significant cognitive deficit, but also requires an adaptive deficit that is currently

ill-defined and, we fear, may be set too high when the draft listings are promulgated. Cognitive deficits such that a person tests at 2 or more standard deviations below the norm, are highly predictive of disability and should not require a significant additional hurdle to clear.

2. Traumatic Brain Injury (TBI)

- **Extend the time frame to twelve months in Section 11.00F for deferring adjudication**

In Section 11.00F, we recommend that SSA extend the time frame of "6 months" to "12 months" for deferring adjudication if a finding of disability is not possible within 3 months post-injury. Yet, SSA must also avoid unnecessarily delaying claims that can be favorably decided within the earlier timeframe.

It is clear in the general neurological medical literature that late onset impairments often occur post-injury, including seizure activity, spasticity and cognitive deficits. Twelve months is a reasonable time frame within which neurologists and neuropsychologists will have a more accurate picture of a patient's deficits, whether the TBI is mild, moderate or severe. Twelve months is also a reasonable time period to allow a TBI patient to undergo more completely a spontaneous recovery.

However, to avoid erroneously denying claims, SSA must be sensitive to the fact that the true picture of long-term functional limitations resulting from TBI may not be fully developed within 2 to 6 months post-injury. The 6-month time period could lead to an erroneous conclusion of improvement in a patient's health status. For example, a person with a TBI may be in a coma for one month with severe cognitive impairments and resulting poor neurological and neuropsychological testing scores. Within one month, the patient may be out of his or her coma and may undergo testing. Within another month (now 3 months post-injury), the same patient may be tested again. Finally, the patient is tested at 6 months post-injury. When the 3-month test scores are compared to the 6-month test scores, the results could reflect a significant improvement in health status/scores that could erroneously reflect a dramatic recovery. Further, a person coming out of a coma may not be physically stable enough to undergo a battery of neurological testing at 6 months post-injury because he or she likely may have motor and attention difficulties or severe agitation. The 12-month time frame allows a reasonable period for spontaneous recovery and accurate test results. Twelve months certainly is a reasonable time frame when one considers the fact that the "healing" period for persons with TBI could be several years -- or never.

On the other hand, SSA must also avoid unnecessarily delaying claims that can be favorably decided earlier in the process, particularly in light of the lengthy administrative appeals process. People who experience TBI often face great disruption in their lives, including the inability to financially support themselves during the recovery process. Access to disability benefits can be crucial during this time. Thus, we recommend that SSA provide clear instructions and criteria to disability adjudicators on the factors needed to determine which TBI claims can be favorably decided and which must be deferred.

- **SSA should add more "A" criteria to Section 12.02, Organic Mental Disorders**

The regulations indicate that TBI cases should be evaluated under 12.02, Organic Mental Disorders, if applicable. However, this listing is sorely inadequate in describing the vast range of mental impairments often experienced by TBI patients. The functional sections or lobes of the brain are divided into the "right" and "left" sides. Each side of the brain is responsible for different functions. Impairments and general dysfunction will vary depending upon the site of injury.

We recommend that SSA add the following requirements in addition to those listed in section "A" or to any other appropriate section in the Listings:

- o Muscle movement and coordination impairments (including left neglect or inattention to the left side of the body and decreased control over left-sided body movements)
- o Hearing, vision, taste, smell and touch impairments (including visual-spatial impairment and visual memory deficits)
- o Sleep disturbance
- o Personality changes
- o Evidence of a loss of intellectual functioning, apart from evidence from formal IQ testing
- o Language impairments (including receptive and expressive language difficulties or understanding language and speaking output)
- o Sequencing difficulties
- o Sexual dysfunction or inappropriate sexual behavior
- o Deficit awareness impairments (see discussion below)

Further, we recommend that SSA add "deficit awareness impairments" to section 12.02 "A" or to any other appropriate section. Deficit awareness impairment is a condition of a brain injury that prohibits a person from using cues from the environment and from peers to change strategies in an attempt to be successful at a work task. Further, deficit awareness impairments do not allow a person with a brain injury to strategize an improvement plan.

It is not uncommon for a person with a brain injury to have difficulty comprehending their deficits and how those deficits affect them day to day and in the workplace. This lack of deficit awareness is significant during the recovery process – extensive rehabilitation may not result in patient improvements because of deficit awareness or because of problems in short- and long-term memory.

The lack of awareness in a person with a brain injury stems from a neurological impairment and often is a consequence of a frontal lobe injury. The frontal lobe is the part of the brain that has the ability to "self-monitor" and to assess behaviors and their possible consequences. A person with a TBI might not know to ask for help at work or when presented with a new situation because they are not aware that their deficits will not allow them to be successful performing certain tasks. In fact, if you ask a person with a deficit awareness impairment how they may perform a task, the person may greatly overstate or overestimate their success. The result is an employee returning to work post-injury who does not ask for assistance or accommodation because he or she simply is not aware of the impairment.

IV. "B" Criteria

- **Revisions to the current criteria**

We have proposed revisions to section 12.00 (see Appendix A) that would create a separate section that discusses the "B" criteria. Currently, they are discussed in the Assessment of Severity section. By creating a separate section, it allows addition of a section immediately following it that discusses the "C" criteria. While keeping the four current "B" criteria intact, we have recommended language that expands the explanation of each factor, thus providing further guidance for adjudicators:

1. Activities of daily living. An additional sentence lists ADLs that are relevant in work activities. These have been incorporated from activities listed in the Mental Residual Functional Assessment form that is currently used by some state DDSs.

2. Social functioning. A sentence has been added that references to specific activities of social functioning that are relevant in work settings, also found in the Mental Residual Functional Assessment form that is currently used by some state DDSs. Another sentence has been added that incorporates social functioning activities in the SSI childhood disability regulations.

3. Concentration, persistence or pace. A sentence has been added that incorporates activities of concentration, persistence, or pace that are found in the Mental Residual Functional Assessment form that is currently used by some state DDSs.

4. Episodes of Decompensation. While we are supportive of the retention of this B criteria, we urge SSA to avoid the use of the sole word "decompensation" because the phrase, as used by most mental health professionals, means a deterioration so severe as to require hospitalization. A better phrase would be "deterioration in overall function" or "deterioration or decompensation," which would include, but would not be limited to, the more severe notion of decompensation. Certainly, an individual is disabled long before their mental status is such that they must be hospitalized repeatedly for extended periods over the course of a year. While the introductory section reflects a concept of deterioration, the use of the term "decompensation," without more, in the listing itself, is misleading both for professionals commenting upon a particular case, and for adjudicators looking through records for instances of "decompensation."

In Section 12.00, we also have changed the phrase "highly structured and directing household" to "intensive supports" to make it consistent with other language in the Introduction defining "highly structured and supportive" settings. The language is similar to that used in the SSI childhood disability listing 112.00.F.

- **Add a new "B" criteria: Communication**

We also urge the adoption of a fifth B criteria, based on the ability to communicate. In reviewing the DSM-IV, it is apparent that the ability or inability to communicate efficiently and effectively is an important measure of the severity of a particular mental illness. While elements

of communication are certainly implicit in assessing social function and ADLs, they do not get the importance they deserve when mixed with these important overarching concepts. Instead, the ability to communicate is often ignored, despite its pivotal importance in obtaining and retaining substantial gainful activity. Just as the childhood listings recognize the importance of communication, and afford it its own domain or area, so too, should the adult listings have a separate B criteria for communication.

V. "C" Criteria

We have proposed language in the Introduction (Appendix A) that amends section 12.00 to create a section that discusses the "C" criteria which allows for greater clarity.

As previously discussed in Section II.2, we urge SSA to provide clear guidance to adjudicators regarding the need to properly recognize and weigh evidence from nonphysician professional sources. The current "C" criteria call for a medically documented history of a particular disorder with periods of decompensation. See, e.g., Listing 12.02 C. Especially during periods of remission, mental health clinics are unlikely to afford patients prolonged exposure to psychiatrists, and, during periods of deterioration or decompensation, such individuals often are not in touch with mental health providers on a regular basis. Much more frequently, the only people who will be able to comment intelligently on a claimant's longitudinal history will be therapists, social workers and others who maintain regular contact with patients.

The explicit requirement of a "medically documented history" of deterioration both serves to relegate the evidence of nonphysician professionals to second-class status and makes it doubly hard to establish disability under these criteria. By making an explicit distinction between the functional evidence allowed in the determination in part B, and the difference between it and part C, the Listings underline the distinction between the two types of evidence, and draw a distinction where none should exist. At the very least, the requirement of medical documentation should be removed from the part C determination.

VI. Factors Relevant to Disability Determinations

We have proposed a new section in the Introduction called "Factors Relevant To The Disability Determinations." The factors discussed below, taken from concepts in the current introductory language, the childhood disability regulations, and Social Security Ruling 85-15 are, when present, relevant in determining disability at all steps of the disability sequential evaluation.

1. **Effects of structured settings.** This has been moved from the current 12.00.
2. **Stress and mental illness.** This section incorporates language currently found in Social Security Ruling (SSR) 85-15.
3. **Extra help.** This section reflects a similar section in the SSI childhood disability regulations.
4. **Unusual settings.** This section expands on a sentence in current section 12.00E and adds more expansive language from the SSI childhood disability regulations.

5. **Effects of medication.** This section is modeled on the SSI childhood disability regulations. It also incorporates language from the current section 12.00G.
6. **Effects of treatment.** This section is the current 12.00H.

VII. Mental Retardation

1. Diagnosis

Mental Retardation A and B Criteria – We strongly support the continued use of Sections 12.05 A. and B. criteria and Sections 112.05 B. and C. criteria to determine disability for people with mental retardation. The provisions are practical and provide clear criteria for determining eligibility for people with the most severe levels of mental retardation.

Standard Error of Measurement (SEM) – We urge SSA to give applicants the benefit of the doubt and include as disabled those individuals whose IQ scores place them within the SEM on standardized tests. The use of hard and fast IQ scores may appear to make the process simpler, but it actually raises the risk of erroneous exclusion and the resulting failure to assist individuals with severe impairments.

Age of Onset – The current listing uses onset before age 22 as the part of the capsule definition/diagnosis for mental retardation under Sections 12.05 and 112.05. We urge SSA to retain the use of age 22 in establishing the capsule definition for eligibility under the mental retardation listing. This is consistent with the onset age of 22 used in the statute for eligibility for disabled adult child benefits.

2. Severity

Sections 12.05C. and D. and Section 112.05D. Severity Level – Mental retardation is a significant and severe disability, including for those people whose IQs test in the range of 60 to 70. To meet the capsule definition of mental retardation, the individual has to show an IQ level at least two standard deviations below the mean (≤ 70) along with deficits in adaptive functioning consistent with the measured IQ. We believe that these two requirements meet the general requirements of having "marked" limitations in two areas (cognition and adaptive functioning). Sections 12.05C. and D. require an additional showing of another impairment imposing significant limitations or a showing of marked restrictions in two listed areas of functioning in order to qualify under the listing. The additional requirements in C. and D. seem to require that individuals assessed under these sections must meet a higher standard than marked limitations in two areas. We urge SSA to re-evaluate the requirements in these two sections because they are inconsistent with the legal framework of the listings and set excessively high standards for two of the four groups of individuals who may qualify with mental retardation. At the very least, we urge the continued interpretation of the requirement of a second, "significant" impairment to require only one that imposes some additional restriction on function.

3. National Research Council (NRC) Recommendations

The National Research Council was commissioned by SSA to evaluate various aspects of coverage for people with mental retardation. The NRC study resulted in a number of recommendations that were presented to SSA in 2002. Here we discuss selected NRC recommendations.

Assessment under other listings – We disagree with the NRC's recommendation that adjudicators "do not need to determine the presence or absence of mental retardation in individuals who are eligible for SSI due to other neurodevelopmental or psychiatric disabilities." In fact, we think it is important that adjudicators establish a complete record for individuals who would qualify by meeting the listing for mental retardation. If mental retardation is present, then adjudicators should explore it as the primary diagnosis. As future changes are made to the listings and other relevant regulations, a complete disability determination record is the best protection for people when they are assessed under the medical improvement standard at the time of their continuing disability reviews (CDRs).

Permanent Presumptive Disability – We support the NRC recommendation to remove work disincentives by "considering individuals with mental retardation to be presumptively re-eligible for benefits throughout their lives, if they have previously received benefits, subsequently secured gainful employment, and then lost that employment." While this may require legislation, especially in the case of people with mental retardation receiving disabled adult child (DAC) benefits, we encourage SSA to propose and to support such legislation. Such a step would remove some major barriers to work for people with the life-long, significant impairment of mental retardation, and ultimately reduce the reliance of many on the SSI and Title II disability programs.

Composite Scores – SSA has a long-standing policy that the NRC did not directly address when it took the position to use composite IQ scores, rather than the lowest of the full scale, performance or verbal subtests. We urge SSA to reject the NRC's recommendation regarding the use of partial or full-scale/composite scores on IQ tests. Composite scores are essentially rough averages that may hide significant information regarding an individual's disability. As a composite, the score is not a valid descriptor of the individual's limitations. The low score has significance and should not be lost in the composite when assessing a particular individual. The lower scores, if not explained by other evidence in the file, should prompt a further consultative examination (CE) of the individual's functioning. As is clear from the NRC's note regarding the dissenting view of panel member Keith Widaman, the NRC recommendation is controversial and we oppose its adoption.

Adaptive Behavior Scores – The NRC recommended using 1 standard deviation below the mean in two adaptive behavior areas or 1.5 standard deviations below the mean in one adaptive behavior area as the measure for ascertaining deficits in adaptive behavior that, along with IQ levels 2 standard deviations below the mean, establish listings-level mental retardation. We endorse this NRC recommendation regarding adaptive behavior scores.

Use of Standardized Behavior Assessment – We agree with the NRC's recommendations that SSA should support more research and development of standardized measures of adaptive behaviors. While the use of standardized measures could improve the outcomes of disability

determinations for people with mental retardation, we recognize that such measures are not currently available to the degree necessary for SSA to make such testing a requirement. Should SSA decide to require the use of standardized testing for adaptive behaviors, we believe that SSA must be prepared to pay reasonable fees for CEs to conduct such assessments when the information is not available in the record.

Impact of Modifications -- The impact of any modifications that SSA makes to the mental retardation listing must be applied only to new applicants, not in continuing disability reviews and not to 18 year olds in SSI. As the result of a suggestion made in the National Research Council's report to SSA, we believe it is important to directly address whether any changes made by SSA would be applicable to continuing disability reviews and to 18 year olds who have been receiving SSI children's disability benefits. Specifically, the NRC believes that its recommended standards for IQ and adaptive behavior should apply also to redeterminations.

While SSA has the ability to use any changes in the listings when redetermining eligibility for benefits in a continuing disability review, should the finding be that the person does not meet the new listing, SSA must apply the old listing to determine if the person will continue to be eligible for benefits. While we urge SSA to limit the changes made to 12.05, it will be essential that any changes to the Listing explain that there will be no impact on current recipients whose conditions have not medically improved and that SSA will rely on the listing in effect at the time the individuals were determined to be eligible. The consequences of not taking this step could be disastrous in the individual lives of many people with mental retardation who depend upon SSI or Social Security benefits for survival and would violate the medical improvement standard included in the statute at 42 U.S.C. § 423(f).

4. Testing

Records of School-Based Testing – When children have Individualized Education Programs (IEPs) in their school files, it is quite likely that the school also has records of testing done to assess the student for the school system. We recommend that SSA routinely request these test results as part of the applicant's file.

Age of Tests – There are several issues regarding old test scores and out-of-date tests that we believe must be addressed.

- We recommend that SSA use consultative examiners for IQ or adaptive behavior tests only if they use current instruments. Instruments are out-of-date if a newer version or edition, with updated norms, has been published.

- SSA should not discount older scores or scores obtained with out-of-date instruments in a claimant's file since many claimants do not have access to state of the art testing and evaluation and should not be penalized for their lack of access. The older test should establish valid history and SSA should ensure that a contemporary test is administered, if necessary, to determine current eligibility.

- If a test in a claimant's file was out-of-date at the time of its administration, SSA should not reject the test entirely; but rather, should make a determination that a new test might be required and order that one be administered at SSA's expense by a consultative examiner

VIII. New Listings Needed

We suggest adding several new listings because of the prevalence of these disorders and the potential to miss them.

1. Post-Traumatic Stress Disorder (PTSD) to 12.06A and 112.06A

PTSD, is a condition found in many members of the armed forces and other victims of and witnesses to violence, terrorism and other traumatic events. Currently it is buried in with 12.06, where it is hard to find, in part because it is never named and only some of the diagnostic criteria of DSM-IV are included.

PTSD is characterized by re-experiencing a specific ordeal in the form of flashback episodes, memories, nightmares, or frightening thoughts, especially when exposed to events or objects reminiscent of the original trauma. Medically documented findings of at least 3 of the following are required:

a. emotional numbness

b. sleep disturbance (e.g., nightmares, insomnia, restless sleep, fear of falling asleep)

c. hypervigilance

d. startle response (e.g., startle reaction to sudden noise or flash of light)

e. easy irritability or outbursts of anger

f. feelings of intense guilt

g. avoidance of reminders or thoughts of a traumatic event

h. flashbacks

i. problems of memory, thinking, or concentration

j. substance abuse originating post-trauma and ingested to suppress memories of the traumatic event with intermittent periods of sobriety and increased use at anniversaries or reminders of the traumatic event.

2. Eating Disorders

We strongly suggest the addition of a particular Listing for Eating Disorders, which have been recognized to be a serious problem for many teens and adults.

Add Listings 12.13A & 112.13A:

Eating Disorders (Anorexia Nervosa, Bulimia, Other Types). *Anorexia nervosa* includes two subtypes that describe distinct patterns: 1) Restricting Type maintains low body weight by restricting food intake and increasing activity (i.e. compulsive exercise); and 2) Binge-Eating/Purging Type restricts food intake but also regularly engages in binge eating and/or purging behaviors (i.e. self-induced vomiting or abuse of laxatives, diuretics, enemas).

a. hyper-sensitive about body image

b. intense fear of weight gain

c. obsessive dieting or starvation (e.g., hoarding food, concealing food, avoiding others who are eating)

d. anhedonia (inability to gain pleasure from normally pleasurable experiences)

e. obsessive exercise, calorie counting

f. self-induced vomiting or excessive use of laxative, diuretics, and/or diet pills

g. amenorrhea in women not related to another hormonal imbalance of other etiology

h. loss of body weight 10% or greater not related to another hormonal imbalance of other etiology

Bulimia Nervosa means recurrent episodes of binge eating, within a discrete period of time (e.g., with a few hours), an amount of food that is greater than most people would consume during a similar period, under similar circumstances; or lack of control over eating (e.g., a feeling that one cannot stop eating or control how much one eats); or recurrent inappropriate compensatory behavior in order to prevent weight gain (e.g., self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, fasting, or excessive exercise) occurring at least twice a week for 3 months.

3. Add Attention Disorders (ADHD, ADD) for adults

This new listing, §12.11, would mirror the children's ADHD Listing, § 112.11.

12.11 Attention Deficit Hyperactivity Disorders: Characterized by inappropriate degrees of inattention, impulsiveness and hyperactivity.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least two of the following:

1. Marked inattention; or

2. Marked impulsiveness; or

3. Marked hyperactivity;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Marked difficulties in sustaining gainful employment.

4. Alzheimer's disease

Alzheimer's disease is the most common cause of dementia, accounting for between 50 to 60% of all cases. Family practitioners, internists or neurologists typically diagnose individuals with Alzheimer's disease. Yet, there is a high prevalence of neuropsychiatric symptoms in dementia and therefore many of these individuals are referred to psychiatrists and other mental health providers for assessment, diagnosis and treatment for these symptoms.

Individuals with Alzheimer's see a variety of practitioners for treatment, including internists, geriatricians, neurologists and psychiatrists, depending on the stage of illness, the presentation of symptoms, the severity of symptoms and secondary complications. There are two different sets of diagnostic codes for Alzheimer's disease and related dementias. In the DSM-IV, the 290 series identifies various dementia codes based on the specific dementia and etiology. In the ICD-9 codes, the 331 series identifies Alzheimer's disease and related dementias as a general medical condition (Axis III). Given that the DSM-IV and ICD-9 codes recognize that these conditions may be both neurological and mental disorders, the listings also should reflect these classifications.

We recommend that Alzheimer's disease be included in 11.15, which is currently reserved, or in 11.17, degenerative disease. These sections should be cross-referenced to 12.02, which should continue to include dementias due to other etiologies. Although all dementias are characterized by development of cognitive deficits and memory impairment, the symptoms and cause vary and should continue to be reflected in the listings. The proposed listing below is consistent with the DSM-IV manual and was developed with input from clinicians from the Mayo Clinic.

Alzheimer's disease – 11.15 or 11.17

A. The gradual onset with progressive and deteriorating course of multiple cognitive deficits manifested by both:

1. memory impairment, and

2. one or more of the following cognitive disturbances:

a. aphasia (loss or impairment of the power to use or comprehend words)
b. apraxia (loss of the ability to execute or carry out learned movements)
c. agnosia (inability to recognize and identify familiar objects or persons)
d. disturbance in executive functioning

AND

B. Resulting in at least one of the following:

1. Marked restriction of activities of daily living, or
2. Marked difficulties in maintaining social functioning, or
3. Marked difficulties in maintaining concentration, persistence, or pace.

5. Autism

There are several types of Pervasive Developmental Delay (PDD), only some of which would diagnostically correlate with the A criteria under Listings 12.11 and 112.11. For some children with atypical PDD, or with Asperger's, for instance, the A criteria requirements are too broad. The preamble to the final rules adding Listings 12.10 and 112.10, published in August 2000, explained that individuals diagnosed with co-morbid autism and mental retardation "can be evaluated under either listing." 65 Fed. Reg. at 50754.

This directive from the Preamble to the final regulations does not address the issue of the interrelation between other PDDs and mental retardation. Moreover, it is unusual for autism to be diagnosed in very young children, even though the behaviors and functional limitations associated with PDD may be identifiable in infancy. As a result of this apparent confusion, some adjudicators eschew these listings when presented with an atypical developmental disorders and inappropriately rely on Listing 12.05 or 112.05 instead. Using Listing 12.05 or 112.05 may be appropriate for many children with autism, but not some with PDDs. Although many with autism have significant limitations in cognitive development at the mental retardation level, some do not, and children with other PDDs may have normal cognitive development, only later regressing.

When the record contains results from intelligence testing but these exceed the requirements of 12.05 and 112.05, the PDD may not be fairly assessed if the claimant is one of those whose PDD has not adversely affected cognitive development. In addition, it is difficult to obtain reliable measures of cognitive development for very young children. Moreover, diagnosing autism (a question of ruling out "other PDD") is difficult prior to ages 2 or 3, so it is not uncommon for the initial diagnosis of an infant with serious limitations to be PDD that only later is recognized as autism. Similarly, some of manifestations of PDDs begin later than 3 years of age (e.g., disintegration disorder generally manifests between 3 and 10 years of age after somewhat normal development earlier). Adjudicators need to be aware of these considerations related to the claimant's age and the corresponding difficulties with making accurate diagnoses of autism and the autistic spectrum disorders.

It is imperative that the PDD component of the Listings encapsulates the PDDs more generically. Specifically, the "verbal and nonverbal" descriptor may not apply to some children with Asperger's or Childhood Disintegrative Disorder, which do not generally affect both domains of communication, and these descriptors may not apply to some children with Rett's Disorder, which generally affects motor, language, and social skills. We recommend that the descriptor for these listings include the phrase "autistic spectrum disorders" to clarify the relationship of PDDs with autism. For these disorders, we also recommend the use of more general descriptors of qualitative deficits without the specific limitation in verbal and nonverbal skills, and we recommend that there is a disjunctive connection with "imaginative activity" so as to capture the very young child's limitations prior to any expected development of the other communication skills. And, following parallel recommendations earlier, we recommend striking the modifier "markedly" from the A criteria.

12.10 *Autistic Disorder and autistic spectrum disorders (other pervasive developmental disorders):* Characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Only where evidence of co-morbid mental retardation exists, evaluate under Listing 12.05. Often with autism, there is a ~~markedly~~ restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied:

A. Medically documented findings of the following:

1. For autistic disorder, all of the following:

a. Qualitative deficits in reciprocal social interaction; and
b. Qualitative deficits in verbal and nonverbal communication and/or ~~in~~ imaginative activity; and
c. ~~Markedly r~~ Restricted repertoire of activities and interests;

OR

2. For other pervasive developmental disorders, both of the following:

a. Qualitative deficits in reciprocal social interaction; and
b. Qualitative deficits in ~~verbal and nonverbal~~ communication ~~and in~~ or imaginative activity;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation or deterioration, each of extended duration.

112.10 *Autistic Disorder and autistic spectrum disorders (other pervasive developmental disorders):* Characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Where evidence of co-morbid mental retardation exists, evaluate under Listing 12.05 or 112.05, as applicable. Often with autism, there is a ~~markedly~~ restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of the following:

1. For autistic disorder, all of the following:

a. Qualitative deficits in reciprocal social interaction; and
b. Qualitative deficits in verbal and nonverbal communication and/or ~~in~~ imaginative activity; and
c. ~~Markedly r~~ Restricted repertoire of activities and interests;

OR

2. For other pervasive developmental disorders, both of the following:

a. Qualitative deficits in reciprocal social interaction; and
b. Qualitative deficits in ~~verbal and nonverbal~~ communication ~~and in~~ or imaginative activity;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraphs B2 of 112.02.

IX. Recommendations of the General Accounting Office (GAO)

Under no circumstances should SSA incorporate the GAO proposals in these Listings. Many of the pharmaceutical and technological advances upon which GAO bases its recommendations are neither uniformly available nor affordable to people with disabilities across our nation.

In its August 2002 report, *SSA and VA Disability Programs: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity,* GAO-02-597, the General Accounting Office raises a number of concerns about how disability is determined in both DI and SSI (as well as VA programs, not at issue here). Some of our comments in other sections of this document are relevant to the GAO's recommendations to SSA as well.

For example, GAO notes that "...SSA does not automatically evaluate individuals applying for benefits under corrected conditions. Thus, it is our belief that the programs themselves have not been fully updated to reflect scientific advances, because interventions that could enhance individuals' productive capacities are not, by design, factored into the disability decision-making process." (page 32) While it some day may be possible to fairly make such a determination, as a practical matter, that day can not come until all people with disabilities or other health conditions can secure the health care they need, including ongoing prescription drugs, counseling, and treatment. While it is possible for some people with mental impairments to work while receiving pharmaceutical treatment that is responsive to their medical conditions, it is often eligibility for SSI and therefore Medicaid that makes it possible to secure needed drugs. For some DI recipients, because Medicare does not include a drug benefit, these individuals may not even be able to secure needed treatment while in benefit status. Loss of SSI often means loss of the very drugs that might make the person employable and therefore less needy of cash assistance.

We urge SSA to ensure that any proposals that incorporate how SSA will evaluate individuals applying for benefits if they were "under corrected conditions" make clear that such a possibility is fantasy — and could have tragic consequences for people with severe mental impairments — if medical care, including free or very reduced price prescription drugs, is not readily available to that specific individual, whether or not he or she is employed after leaving DI or SSI and for however long as needed to ensure the person can continue to remain independent of DI and SSI.

X. Other Listings Issues

1. Functional equivalence (FE) for adults

We urge SSA to replicate and draw from the work of the SSA/AUCD Children's SSI Project over the past five years and develop a functional equivalence step to assess adults who do not meet the particular criteria of specific listings. This recommendation has special significance for younger adults with mental impairments, particularly those who have not worked; Steps 4 and 5 in the disability determination process are inadequate for addressing them. SSA should develop and implement an effective method to assess adults at the listings level when their impairments do not fall within specific listings. This could be done by creating a functional equivalence step for adults, using the concepts developed in assessing functional equivalence for children, or by improving the RFC process to ensure its relevance for younger adults. In either case, SSA should develop an approach, similar to the childhood FE, which looks at the impact of impairment across the domains of function critical for an adult to function in competitive employment.

2. Use of regulations

We urge that SSA construct the children's mental disorder listings so that people do not have to refer back and forth between different listings to find the functional criteria. While this would require repetition of criteria in each of the separate listings, the added clarity for users would be well worth it.

3. Consultative examinations

We urge SSA to make use of consultative examiners (CEs) on a broader scale than in current practice. Additional information would assist adjudicators in making better decisions in many cases. We urge the following:

- SSA should reinforce the Disability Determination Services' (DDS) responsibility to use consultative examinations to acquire additional or "missing" evidence.

- SSA should particularly emphasize the use of vocational CEs for people who have no real employment history. This is of particular importance for younger adults who are finishing their special education, but who have not been tested in the job market.

SSA should encourage the use of clinical social workers as CEs to collect evidence on medical and social history from individuals and families. SSA should treat evidence from appropriately state-certified clinical social workers as "medical evidence," especially where this information helps establish the medical and social history for the individual.

XI. Issues Outside the Listings

1. Improve full development of the record earlier in the process

Developing the record so that relevant evidence from all sources can be considered is fundamental to full and fair adjudication of claims. The decisionmaker needs to review a wide variety of evidence in a typical case, including: medical records of treatment; opinions from medical sources and other treating sources, such as social workers and therapists; records of prescribed medications; statements from former employers; and vocational assessments. The decisionmaker needs these types of information to determine the claimant's residual functional capacity, ability to return to former work, and ability to engage in other work which exists in the national economy in significant numbers. Once an impairment is medically established, SSA's regulations envision that all types of relevant information, both medical and nonmedical, will be considered to determine the extent of the limitations imposed by the impairment(s).

The key to a successful disability determination process is having an adequate documentation base and properly evaluating the documentation that is obtained. Unless claims are better developed at earlier levels, the procedural changes will not improve the disability determination process. Unfortunately, very often the files that denied claimants bring to their representatives show that inadequate development was done at the initial and reconsideration levels. Until this lack of evidentiary development is addressed, the correct decision on the claim cannot be made. Claimants are denied **not** because the evidence establishes that the person **is not disabled**, but because the limited evidence gathered cannot establish that the person **is disabled**.

A properly developed file is usually before the ALJ because the claimant's representative has obtained evidence or because the ALJ has developed it. Not surprisingly, different evidentiary

records at different levels can easily produce different results on the issue of disability. To address this, the agency needs to emphasize the full development of the record at the beginning of the claim.

We support full development of the record at the beginning of the claim so that the correct decision can be made at the earliest point possible. Claimants should be encouraged to submit evidence as early as possible. However, the fact that early submission of evidence does not occur more frequently is usually due to reasons beyond the claimant's control.

Our recommendations to improve the development process include the following:

- SSA should explain to the claimant, at the beginning of the process, what evidence is important and necessary.

- DDSs need to obtain necessary and relevant evidence. Representatives often are able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. The same effort should be made with nonphysician sources (e.g., therapists, social workers) who see the claimant more frequently than the treating doctor and have a more thorough knowledge of the limitations caused by the claimant's impairments.

- Improve treatment source response rates to requests for records, including more appropriate reimbursement rates for medical records and reports.

- Provide better explanations to medical providers, in particular treating sources, about the disability standard and ask for evidence relevant to the standard.

2. Administrative process

The SSDI and SSI application processes can be both lengthy and complex. Often, persons with mental impairments may have difficulty even applying for benefits at a crowded SSA field office, unless they are provided with assistance. And, if an individual with a mental impairment does file an application, he or she frequently has difficulty in completing the voluminous paperwork – particularly in providing an accurate psychiatric history and a full record of hospitalizations or other medical treatment. Finally, a person with mental illness is likely to struggle in attending appointments – either for CEs or for hearings. Failure to appear at these appointments can result in a claim being dismissed.

Even when a person with a mental impairment is able to pursue their application, claimants are commonly denied at both the initial application and reconsideration levels. These claimants must then file for a hearing before an Administrative Law Judge (ALJ). While a significant percentage of claimants are granted benefits by ALJs, many claimants with mental impairments are unable to file appeals, and thus they never have this additional opportunity to demonstrate their disability. Ironically, the current process results in people whose disabilities make them the

least able to file an appeal form being denied benefits, while others who are less impaired, but are still disabled, will be awarded SSDI and/or SSI.

When a person with a mental impairment does receive SSDI or SSI, they are often required to have a representative payee. Many people, particularly those who are homeless or who have lost most social connections, do not have anyone that they can turn to as a reliable payee. Unfortunately, an insufficient number of local service providers are willing to serve as payees. As a result, friends or family members who serve as payees take advantage of many low-income persons only because nobody else is available.

Because these problems severely impact SSDI and SSI applicants with mental impairments, we offer the following recommendations to help improve the process. It is our belief that implementation of these recommendations would be of great benefit to claimants, while also moving claims through the application process more efficiently.

Pre-Application

- SSA should institutionalize SSDI/SSI outreach to low-income persons with mental disabilities. The focus of this outreach should be on specific populations that have a high incidence of mental impairments, such as homeless persons or children in particular areas.

Application Process:

- SSA should expand its use of pre-release agreements, to take more applications before claimants leave public institutions such as hospitals, jails, or prison.

- SSA should provide claimants who have mental impairments with additional accommodations, including assistance in completing applications and other forms, and flexibility in scheduling appointments for CEs or ALJ hearings.

- SSA should explicitly recognize that assertion of a mental impairment may be sufficient to demonstrate good cause for failure to file a timely appeal or other SSA document. This currently is SSA's policy, as codified in SSR 91-5p; yet, adjudicators often do not follow the policy. According to SSR 91-5p:

> When a claimant presents evidence that mental incapacity prevented him or her from timely requesting review of an adverse determination ... at the time of the prior administrative action, SSA will determine whether or not good cause exists for extending the time to request review. If the claimant satisfies the substantive criteria, the time limits in the reopening regulations do not apply; so that, ***regardless of how much time has passed since the prior administrative action***, the claimant can establish good cause for extending the deadline to request review of that action. (emphasis added)

Adjudication Process:

- SSA should focus on rapid development of case files, as soon as claims are taken. This should involve building connections with state Mental Health / Mental Retardation agencies, to ensure that providers funded by those agencies are trained on how to quickly submit claimant treatment records to SSA.

- SSA should also focus on expanding the use of presumptive eligibility for persons with mental impairments. Specifically, presumptive eligibility criteria should be revised to indicate that persons with a well-documented history of serious and persistent mental illness can be found presumptively eligible for SSI. And, SSA should seek to expand demonstration programs such as the SSI Advocacy Project in Baltimore, MD. – a former SSA demonstration program that is now independently funded. The SSI Project works with people who are homeless and mentally ill and has received special permission from SSA to submit cases for presumptive eligibility based solely or primarily on mental impairments.

Post-Eligibility

- SSA should make additional efforts to recruit qualified representative payees. In addition, SSA should devote more time to assisting beneficiaries with mental impairments with obtaining reliable representative payees.

3. Drug addiction and alcoholism

We urge SSA to provide guidance in the Introduction, Section 12.00, on the disability analysis of combinations of substance use disorders and mental impairments. Although the current standard was established by Pub. L. No. 104-121 in 1996, the regulations at 20 C.F.R. §§ 404.1535(b) and 416.935(b) have not been revised and still apply the prior standard. The only complete source of SSA's policy on the analysis of combinations of substance use disorders and mental impairments is contained in subregulatory instructions in EM 96- (8/30/96). The out-of-date regulations and the inaccessibility of the subregulatory materials result in confusion and incorrect determinations. Given the common co-morbidity of substance use disorders and mental impairments, it is critical that SSA include the language we have proposed in Appendix A to help assure fair and correct disability determinations.

4. Specialized adjudicators for childhood mental and physical disorders

SSA and DDS adjudicators must operate as generalists who must be as expert in analyzing a 60 year-old man's claim as an infant's claim. The medical and health provider world has long stepped away from this approach, recognizing the substantial differences and need for specialist expertise in evaluating medical and functional problems of adults and children. It took the SSA central office, almost 20 years after the inception of the SSI program, to establish its Children's Disability Bureau within the Office of Disability. Many DDSs have de facto adopted various aspects of specialist attention for children. SSA should encourage DDSs to adopt specialization within its staff for children's cases.

5. Psychotherapy treatment records

SSA currently uses its general client signed release form, SSA 827 (signed in the field office) to obtain medical and clinical records, but under the HIPAA regulations, which require specific informed release for psychotherapy notes and records, mental health providers do not send these records. What is worse, SSA has acquiesced in this situation, and a negative inference against the claimant is often made, discounting this source because of the lack of this underlying documentation.

SSA needs to immediately address this by amending SSA 827 to specifically and explicitly cite psychotherapy records as covered by the release, and to take other steps as necessary, in the period before the form is revised, to achieve this same end.

In the alternative, if SSA has administratively decided to explicitly exclude psychotherapy notes from its general release form, adjudicators should be instructed to make no negative inference from the omission of these documents from the record. Some mental health facilities may uphold a more restrictive rule than HIPAA imposes regarding the release of patient records and claimants should not be adversely affected by these more stringent rules protecting patient privacy.

6. Referral of children to Medicaid and State CHIP Programs

Access to health insurance is essential for all children applying for SSI, both to treat and ameliorate existing health problems causing the disability and to lessen their time on SSI. The Mississippi pilot of referrals from SSA field offices to the State Medicaid and State Children's Health Insurance Program (CHIP) agencies shows the great efficiency and success of this proposal. The total national cost to SSA of this proposal has been determined by SSA to be only $1 million. Even this cost would be halved in those section 1634 states (more than half in the nation) utilizing the SSA SDX computer tape, shared with the state, which includes SSI child disability applicant children and their health insurance status.

This reform should be rolled out nationally to ensure that the most vulnerable low-income children in the nation, those with disabilities and chronic health problems, receive the health insurance for which they are already eligible.

7. Culturally competent assessment tools and process

When considering whether or not an individual meets the definition of "disability," we recommend that careful consideration be given to the individual's culture and primary language. In addition, when gathering evidence to make a disability determination, we urge SSA to make sure those assessments, tests and evaluations performed on applicants are done in a manner that is culturally and linguistically relevant.

APPENDIX A to CCD Comments

Proposed Revised Mental Impairments Introduction Language

12.00 Mental Disorders

A. *Introduction.* The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on your ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in nine diagnostic categories: Organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation (12.05); anxiety-related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); substance addiction disorders (12.09); and autistic disorder and other pervasive developmental disorders (12.10). Each listing, except 12.05 and 12.09, consists of a statement describing the disorder(s) addressed by the listing, paragraph A criteria (a set of medical findings), and paragraph B criteria (a set of impairment-related functional limitations). There are additional functional criteria (paragraph C criteria) in 12.02, 12.03, 12.04, and 12.06, discussed herein. We will assess the paragraph B criteria before we apply the paragraph C criteria. We will assess the paragraph C criteria only if we find that the paragraph B criteria are not satisfied. We will find that you have a listed impairment if the diagnostic description in the introductory paragraph and the criteria of both paragraphs A and B (or A and C, when appropriate) of the listed impairment are satisfied.

The criteria in paragraph A substantiate medically the presence of a particular mental disorder. Specific symptoms, signs, and laboratory findings in the paragraph A criteria of any of the listings in this section cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) indicated by the medical findings. However, we may also consider mental impairments under physical body system listings, using the concept of medical equivalence, when the mental disorder results in physical dysfunction. (See, for instance, 12.00D12 regarding the evaluation of anorexia nervosa and other eating disorders.) In addition, some physical impairments are analyzed under mental system listings, when the physical disorders result in mental dysfunction. (See, for instance, 3.10 regarding evaluation of sleep-related disorders; 11.05 regarding evaluation of brain tumors; 11.09 regarding evaluation of multiple sclerosis; 11.17B regarding evaluation of chronic brain syndrome; and 14.02A regarding evaluation of systemic lupus erythematosus.

[1]

The criteria in paragraphs B and C describe impairment-related functional limitations that are incompatible with the ability to do any gainful activity. The functional limitations in paragraphs B and C must be the result of the mental disorder described in the diagnostic description, that is manifested by the medical findings in paragraph A.

The structure of the listing for mental retardation (12.05) is different from that of the other mental disorders listings. Listing 12.05 contains an introductory paragraph with the diagnostic description for mental retardation. It also contains four sets of criteria (paragraphs A through D). If your impairment satisfies the diagnostic description in the introductory paragraph and any one of the four sets of criteria, we will find that your impairment meets the listing. Paragraphs A and B contain criteria that describe disorders we consider severe enough to prevent your doing any gainful activity without any additional assessment of functional limitations. For paragraph C, we will assess the degree of functional limitation the additional impairment(s) imposes to determine if it significantly limits your physical or mental ability to do basic work activities, *i.e.,* is a "severe" impairment(s), as defined in §§404.1520(c) and 416.920(c). If the additional impairment(s) does not cause limitations that are "severe" as defined in §§404.1520(c) and 416.920(c), we will not find that the additional impairment(s) imposes "an additional and significant work-related limitation of function," even if you are unable to do your past work because of the unique features of that work. Paragraph D contains the same functional criteria that are required under paragraph B of the other mental disorders listings.

The structure of the listing for substance addiction disorders, 12.09, is also different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances. In addition, substance abuse disorders are covered by additional rules. First, we must determine whether you are disabled, considering all your impairments, including any substance use disorders. If we find that you are disabled, we must then determine whether there is medical evidence of drug addiction or alcoholism from a medically acceptable source that is sufficient and appropriate to establish that you have a medically determinable substance use disorder. If you meet the disability criteria and if there is medical evidence of a substance use disorder, we must then determine whether your drug addiction or alcoholism is a contributing factor material to the disability determination. The materiality determination requires us to separate the restrictions and limitations resulting from your medically determined substance use disorder from those resulting from your other medically determined impairments. If you meet the disability criteria without consideration of the restrictions and limitations resulting from your substance use disorder, we will find that your substance use is not material to the disability determination. The most complicated and difficult

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1 This ~~I inserted this~~ language was inserted to show that, just as mental impairments are sometimes evaluated under physical listings, the converse is also true. ~~I listed the instances in the~~ Listings in which ~~where~~ physical impairments are evaluated under the mental listings are set forth.

determinations of materiality will involve substance use disorders and one or more mental impairments. If we cannot disentangle the limitations and restrictions of your substance use disorder from those of your other impairments, we will find that substance use is not material to the disability determination. This analysis applies to all impairments, including those caused by substance abuse, e.g., alcoholic cirrhosis, neuropathies, organic brain damage.[2] ~~If you meet the disability criteria without consideration of the effects of drug addiction or alcoholism, we will find you disabled, even if your disability was caused by drug addiction or alcoholism.~~

The listings are so constructed that an individual with an impairment(s) that meets or is equivalent in severity to the criteria of a listing could not reasonably be expected to do any gainful activity. These listings are only examples of common mental disorders that are considered severe enough to prevent an individual from doing any gainful activity. There are many other mental impairments that are not specifically identified within the Listings (e.g., eating disorders, post-traumatic stress disorders, learning disorders, attention deficit disorders, alzheimer's or other dementias) which may be medically equivalent to the Listings criteria.

When you have a medically determinable severe mental impairment that does not satisfy the diagnostic description or the requirements of the paragraph A criteria of the relevant listing, the assessment of the paragraph B and C criteria is critical to a determination of equivalence. If your functional limitations satisfy the paragraph B or paragraph C criteria and those functional limitations are the result of a medically determinable impairment or combination of medically determinable impairments, your impairment(s) is considered severe enough to prevent you from doing any gainful activity.[3]

If your impairment(s) does not meet or is not equivalent in severity to the criteria of any listing, you may or may not have the residual functional capacity (RFC) to do substantial

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2 This language is taken from EM-96- (8-30-96), Q& A 13, 22, 23, 27, 28, 29. Q & A 22 identified substance use disorders as the term used by the DSM-IV and the term SSA has chosen to equate with the statutory term DAA. We urge SSA to provide guidance in the mental impairment listings preface on the disability analysis of combinations of substance use disorders and mental impairments. Although the current standard was established by Public Law 104-121 (March 29, 1996), the regulation at 20 C.F.R. §§ 404.1535(b), 416.935(b) have not been revised and still apply the prior standard. The only complete source of SSA's policy on the analysis of combinations of substance use disorders and mental impairments is contained in the subregulatory instructions in EM-96- (8-30-96). The outdated regulations and inaccessibility of the subregulatory materials results in confusion and incorrect determinations. Given the frequency in which claimants have both substance use disorders and mental impairments, it is critical that SSA include this proposed language.

3 This language makes clear that if someone's functional limitations are severe enough to meet either the paragraph B or C criteria and those functional limitations are caused by a medically determinable impairment(s), then that person satisfies the listings (either meeting if s/he satisfies a listing's A criteria or medically equaling if the person cannot exactly meet any specific A criteria. ~~This reflects my belief that~~ T~~t~~he ~~important~~ focus of the mental listings is the impact of functional limitations which are assessed with the B and C criteria.

gainful activity (SGA). The determination of mental RFC is crucial to the evaluation of your capacity to do SGA when your impairment(s) does not meet or equal the criteria of the listings, but is nevertheless severe.

RFC is a multidimensional description of the work-related abilities you retain in spite of your medical impairments. An assessment of your RFC complements the functional evaluation necessary for paragraphs B and C of the listings by requiring consideration of an expanded list of work-related capacities that may be affected by mental disorders when your impairment(s) is severe but neither meets nor is equivalent in severity to a listed mental disorder.

B. *Need for medical evidence.* We must establish the existence of a medically determinable impairment(s) of the required duration by medical evidence consisting of symptoms, signs, and laboratory findings (including psychological test findings). Symptoms are your own description of your physical or mental impairment(s). Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, *e.g.,* abnormalities of behavior, mood, thought, memory, orientation, development, or perception, as described by an appropriate medical source. Symptoms and signs generally cluster together to constitute recognizable mental disorders described in the listings. The symptoms and signs may be intermittent or continuous depending on the nature of the disorder. Laboratory findings include psychological test findings; intelligence test findings; personality measures and projective testing techniques; neuropsychological assessments; and in some cases, screening tests. See 20 C.F.R. §§ 404.1528, 416.928. Diagnosing and treating mental impairments involve verbal and behavioral communications with mental health professionals, so we will consider self-reports, and the reports of others made about you to mental health professionals, to be crucial evidence of the severity of your impairments if a mental health professional(s) has relied on these descriptions to inform clinical judgment. When a medical source has accepted and relied upon such information to make a diagnosis or treatment decision about your impairment(s), we will consider this information to be a clinical sign, as defined in §§ 404.1528(b) and 416.928(b). Signs, symptoms, and laboratory findings are discussed in greater detail below in F.[4]

C. *Assessment of severity.* We measure severity according to the functional limitations imposed by your medically determinable mental impairment(s). We assess functional limitations using the four criteria in paragraph B of the listings: Activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. Your impairment(s) satisfies the mental listings if you have "marked" limitations in two

4 ~~I added~~ This language was added because the current paragraph discusses signs and symptoms, but does not define or discuss laboratory findings. ~~I also added to~~ A cross-reference to the more detailed discussion of different types of evidence in newly labeled section F is added.

of the four paragraph B criteria or an "extreme" limitation in one of the four paragraph B criteria. We explain what the terms "marked" and "extreme" mean below.[5]

Where we use "marked" as a standard for measuring the degree of limitation, it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired, or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with your ability to function independently, appropriately, effectively, and on a sustained basis. See §§404.1520a and 416.920a. It is the equivalent of the functioning we would expect to find on standardized testing with scores that are at least two, but less than three, standard deviations below the mean.[6]

Where we use "extreme" as a standard for measuring the degree of limitation, it means a limitation that is "more than marked." An extreme limitation may arise when several activities or functions are impaired in an area considered, or even when only one is impaired, as long as the degree of limitation is such as to interfere very seriously with your ability to function independently, appropriately, effectively, and on a sustained basis. "Extreme" limitation is the rating we give to the worst limitations. However, "extreme limitation" does not necessarily mean a total lack or loss of ability to function. It is the equivalent of the functioning we would expect to find on standardized testing with scores that are at least three standard deviations below the mean.[7]

D. *Paragraph B Criteria*[8]

1. *Activities of daily living* are the everyday activities involved in caring for and about yourself. These include the capacity to function independently, appropriately, effectively, and adaptively in ~~include adaptive activities~~ such activities as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for your grooming and hygiene, using telephones and directories, ~~and~~ using a post office, following treatment recommendations, taking medication as prescribed,

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5 This introduces the concept, already set forth in the children's disability standard, that a person meets and/or equals the listings if s/he has two marked limitations or one extreme limitation. See 20 C.F.R. § 416.926a(d).

6 Addition of this language makes the definition of marked consistent with the definition used in childhood disability. The only change is to state that test results that are two to three standard deviations below the norm are also evidence of a marked limitation. See 20 Part 404, Subpart P, § 112.00.C; 20 C.F.R. § 416.926a(e)(2).

7 Because ~~I have introduced~~ the concept that an extreme limitation is disabling has been introduced above, it is defined here. ~~I have provided a definition of extreme.~~ This definition tracks the definition of extreme used in childhood disability case. See 20 C.F.R. § 416.926a(e)(2).

8 In the current regulations, the paragraph B criteria are discussed in the Assessment of Severity section. I have severed the paragraph B criteria and made it a separate section for clarity. Also, it allows addition~~me to add~~ of another section immediately after that discusses the paragraph C criteria in detail.

carrying out simple instructions, maintaining personal appearance and health, and generally coping with the routine stresses of daily life. In the context of your overall situation, we assess the quality of these activities by their independence, appropriateness, effectiveness, and sustainability. We will determine the extent to which you are capable of initiating and participating in activities independent of supervision or direction.

Additional a~~A~~ctivities of daily living particularly relevant in work activities are the ability to respond appropriately to changes in the work setting; the ability to recognize ~~be aware of~~ normal hazards and take appropriate safety precautions; the ability to travel in unfamiliar places or use public transporation; ~~and~~ the ability to set realistic goals or make plans independently of others;[9] and the ability to properly manage and maintain a work station. In the context of your overall situation, we assess the quality of these activities by their independence, appropriateness, effectiveness, and sustainability. We will determine the extent to which you are capable of initiating and participating in activities effectively, independent of supervision or direction.

~~W~~We do not define "marked" by a specific number of different activities of daily living in which functioning is impaired, but by the nature and overall degree of interference with function. For example, if you do a wide range of activities of daily living, we may still find that you have a marked limitation in your daily activities if you have serious difficulty performing them without direct supervision, or in a suitable manner, or on a consistent, useful, routine basis, or without undue interruptions or distractions.

2. *Social functioning* refers to your capacity to interact independently, appropriately, effectively, and on a sustained basis with other individuals. Social functioning includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. Social functioning also requires the ability, on a sustained basis, to respond appropriately to a variety of emotional and behavioral cues, participate in verbal and nonverbal exchanges, consider the feelings and points of view of others, and follow social rules for interaction and conversation.[10] You may demonstrate impaired social functioning by, for example, ~~a history of altercations, evictions, firings, fear of strangers,~~ avoidance of interpersonal relationships, or social isolation, or difficulties communicating with others, or problems in interacting or emotionally relating to others. You may exhibit strength in social functioning by such things as your ability to initiate social contacts with others, communicate clearly and effectively with others, or interact and actively participate in group activities. We also need to consider cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity. Social functioning in work or work-like situations may involve ~~interactions with the public, responding appropriately to persons in authority (*e.g.*, supervisors), or cooperative~~

9 This sentence, which lists activities of daily living that are relevant in work activities, incorporates activities that are listed in an SSA form—Mental Residual Functional Assessment—that is currently used by some state BDDSs (at least it is used by the Illinois BDDS). See SSA-4734-F4-SUP (8/85).

10 See 20 C.F.R. § 416.926a(i)(1)(iii) & (2)(iv).

~~behaviors involving coworkers.~~ the ability to interact appropriately with the general public; the ability to ask simple questions or request assistance; the ability to accept instructions and respond appropriately to criticism from supervisors; ~~and~~ the ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes;~~.~~[11] and the ability to interact independently, appropriately, effectively and on a sustained basis with other individuals in a social or work related environment, including your ability to remember people, incidents and facts and to engage succesfully in problem solving around tasks or social interactions.

We do not define "marked" by a specific number of different behaviors in which social functioning is impaired, but by the nature and overall degree of interference with function. For example, if you are highly antagonistic, uncooperative, or hostile but are tolerated by local storekeepers, we may nevertheless find that you have a marked limitation in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence, or pace* refers to the ability to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings. Limitations in concentration, persistence, or pace are best observed in work settings but may also be reflected by limitations in other settings. When evaluating concentration, persistence or pace based on performance in work settings, we will consider whether the work was performed in structured or supportive settings such as work in supported employment, transitional employment or sheltered employment and whether special supports were provided. In addition, major limitations in ~~this area~~ concentration, persistence or pace can often be assessed through clinical examination or psychological testing. Wherever possible, however, a mental status examination or psychological test data should be supplemented by other available evidence. Concentration, persistence, and pace in work situations may involve the ability, on a sustained basis, to carry out very short and simple instructions; the ability to carry out detailed instructions; the ability to maintain attention and concentration for extended periods; the ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; the ability to sustain an ordinary routine without special supervision; the ability to work in coordination with or proximity to others without being distracted by them; the ability to make simple work decisions; and the to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace with an unreasonable number of length of rest periods.[12]

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11 This sentence, which lists social functioning abilities that are relevant in work activities, incorporates activities that are listed in an SSA form—Mental Residual Functional Assessment—that is currently used by some state BDDSs (at least it is used by the Illinois BDDS). See SSA-4734-F4-SUP (8/85).

12 This sentence, which lists activities of concentration, persistence, and pace that are relevant in work activities, incorporates activities that are listed in an SSA form—Mental Residual Functional Assessment—that is currently used by some state BDDSs (at least it is used by the Illinois BDDS). See SSA-4734-F4-SUP (8/85).

On mental status examinations, deficiencies in concentration may be monitored ~~is assessed~~ by tasks such as having you subtract serial sevens or serial threes from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits.

In work evaluations, concentration, persistence, or pace is assessed by testing your ability to sustain work using appropriate production standards, in either real or simulated work tasks (*e.g.*, filing index cards, locating telephone numbers, or disassembling and reassembling objects). Strengths and weaknesses in areas of concentration and attention can be discussed in terms of your ability to work at a consistent pace for acceptable periods of time and until a task is completed, and your ability to repeat sequences of action to achieve a goal or an objective.

We must exercise great care in reaching conclusions about your ability or inability to complete tasks under the stresses of employment during a normal workday or work week based on a time-limited mental status examination or psychological testing by a clinician, or based on your ability to complete tasks in other settings that are less demanding, highly structured, or more supportive. We must assess your ability to complete tasks by evaluating all the evidence, with an emphasis on how independently, appropriately, and effectively you are able to complete tasks on a sustained basis.

We do not define "marked" by a specific number of tasks that you are unable to complete, but by the nature and overall degree of interference with function. You may be able to sustain attention and persist at simple tasks but may still have difficulty with complicated tasks. Deficiencies that are apparent only in performing complex procedures or tasks would not satisfy the intent of this paragraph B criterion. However, if you can complete many simple tasks, we may nevertheless find that you have a marked limitation in concentration, persistence, or pace if you cannot complete these tasks without extra supervision or assistance, or in accordance with quality and accuracy standards, or at a consistent pace without an unreasonable number and length of rest periods, or without undue interruptions or distractions.

4. *Episodes of decompensation* means deterioration of the individual's existing positive coping strategies, leading to an exacerbation of signs or symptoms and the need for intervention that may require an increase in medication, more frequent or intensive counseling, less stressful situations, or, in extreme cases, psychiatric hospitalization. ~~are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace.~~ Individuals may function relatively well for relatively long periods of time between periods of decompensation.[13] ~~E(65 Fed Reg. 50770 (8/21/00) Episodes of~~

13 65 Fed Reg. 50770 (8/21/00).

~~decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two).~~ Episodes of decompensation may be inferred from ~~medical~~ records showing significant alteration in medication; ~~or~~ documentation of ~~the need for a~~ more ~~structured psychological support system (e.g., hospitalizations, placement in a halfway house, or a highly structured and supportive~~directing household)[14] intensive support; or other relevant information in the record about the existence, severity, and duration of the episode. The need for a more structured setting (e.g., psychiatric hospitalization, placement in a day program or halfway house, or a highly structured and directing household) may demonstrate an extreme limitation in functioning that would satisfy the criteria of paragraph C in the Listings (described below).

The term *repeated episodes of decompensation, each of extended duration* in these listings means three episodes of deterioration in your functioning within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks. If you have experienced more frequent episodes of shorter duration or less frequent episodes of longer duration, we must use judgment to determine if the duration and functional effects of the episodes are of equal severity and may be used to substitute for the listed finding in a determination of equivalence. Precise documentation of the beginning and ending of episodes is not necessary. 65 Fed. Reg. 50771 (Aug. 21, 2000).

E. *Paragraph C Criteria.*[15] The paragraph C criteria reflect that evaluation of the severity of mental impairments is particularly difficult for individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Such individuals structure their lives in order to minimize their stress and reduce their symptoms and signs. In such a case, such individuals may be much more impaired for work than their symptoms and signs would indicate. As a result, the paragraph C criteria provide an alternative method of assessment for individuals with chronic mental impairments (medically documented history of a medically determinable impairment or combination of medically determinable impairments of at least 2 years' duration) if we find that the paragraph B criteria are not satisfied.[16]

F. *Factors relevant to disability determinations.* The factors ~~The five concepts~~ discussed below ~~, while relevant to the Paragraph C criteria,~~ are, when present, relevant in determining disability ~~may also be relevant~~ at all steps of the disability sequential evaluation.

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14 SSA does not define "highly structured and directing household". It does define "structured and supportive setting" in current § 112.00.F. The change is made to allow cross-reference of this section for definition.

15 As with the paragraph B criteria, ~~I have created~~ a section that specifically discusses different factors relevant to paragraph C analysis is added for greater clarity.

16 This introductory sentence to the paragraph C criteria section incorporates language from 12.00A, 12.00E, and the C criteria in specific listings.

1. *Effects of structured settings.* Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, halfway house, board and care facility, or other environment that provides similar structure. ~~Highly s~~Structured and supportive settings may also be found in your home and in supported, sheltered, or transitional work programs. A structured or supportive setting may minimize signs and symptoms of your impairment(s) and help to improve your functioning while you are in it, but your signs, symptoms, and functional limitations may worsen outside this type of setting. Therefore, we will consider your need for a structured setting and the degree of limitation in functioning you have or would have outside the structured setting. Even if you are able to function adequately in the structured or supportive setting, we must consider how you function in other settings and whether you would continue to function at an adequate level without the structured or supportive setting.

If you have a chronic impairment(s), you may have your activities structured in such a way as to minimize stress and reduce the symptoms or signs of your impairment(s). You may continue to have persistent symptoms or signs or functional limitations, although perhaps at a lesser level of severity. We will consider whether you are more limited in your functioning than your symptoms and signs would indicate.

Therefore, if your symptoms or signs are controlled or reduced in a structured setting, we will consider how well you are functioning in the setting and the nature of the setting in which you are functioning (*e.g.*, home or mental health program or supported work setting); the amount of help you nee to maintain your present level of functioning as well as you do; adjustments you make to structure your environment for yoursel; and how you would function without the structured or supportive setting being available to you.

For these reasons, identical paragraph C criteria are included in 12.02, 12.03, and 12.04. The paragraph C criterion of 12.06 reflects the uniqueness of agoraphobia, an anxiety disorder manifested by an overwhelming fear of leaving the home.[17]

2. *Stress and Mental Illness* — Since mental illness is defined and characterized by maladaptive behavior, it is not unusual that individuals with mental impairments have difficulty accommodating to the demands of work and work-like settings. Determining whether these individuals will be able to adapt to the demands or "stress" of the workplace is often extremely difficult. This section is not intended to set out any presumptive limitations for disorders, but to emphasize the importance of thoroughness in evaluation on an individualized basis.

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17 This section incorporates the childhood disability discussion of structured settings; it provides a framework for assessing the impact of such settings, something not included in the current adult regulations. See 20 C.F.R. § 416.924a(b)(5)(iv).

Individuals with mental disorders often adopt a highly restricted and/or inflexible lifestyle within which they appear to function will. Good mental health services and care may enable chronic patients to function adequately in the community by lowering psychological pressures, by medication, and by support from services such as outpatient facilities, day care programs, social work programs and similar assistance.

The reaction to the demands of work (stress) is highly individualized, and mental illness is characterized by adverse responses to seemingly trivial circumstances. Individuals with mental impairments may not function effectively when facing such demands as getting to work regularly, having their performance supervised, and remaining in the workplace for a full day. A person may become panicked and develop palpitations, shortness of breath, or feel faint while riding in an elevator; another may experience terror and begin to hallucinate when approached by a stranger asking a question. Thus, individuals with mental impairments may have difficulty meeting the requirement of even so-called "low stress" jobs.

Because response to the demands of work is highly individualized, the skill level of a position is not necessarily related to the difficulty an individual will have in meeting the demands of the job. A claimant's condition may make performance of an unskilled job as difficult as an objectively more demanding job. For example, a busboy need only clear dishes from tables. But an individual with a severe mental disorder may find unmanageable the demand of making sure that he removes all the dishes, does not drop them, and clears the table promptly for the waiter or waitress. Similarly, an individual who cannot tolerate being supervised may be not able to work even in the absence of close supervision; the knowledge that one's work is being judged and evaluated, even when the supervision is remote or indirect, can be intolerated for some mentally impaired persons. Any impairment-related limitations created by an individual's response to demands of work, however, must be reflected in the RFC assessment.[18]

3. *Extra Help.* We will consider how independently you are able to function independent of supervision, direction, or cuing. We will consider whether you need help from other people, or whether you need special equipment, devices, or medications to perform your day-to-day activities.[19]

~~4~~3. *Unusual Settings.* You may function differently in unfamiliar or one-to-one settings then you do in usual settings. Thus, the results of a single examination may not adequately describe your sustained ability to function. You may appear more or less impaired on a single examination (such as a consultative examination) than indicated by the information covering a longer period. It is, therefore, vital that we review all pertinent information relative to your condition, especially at times of increased stress. We will

18 This new section sets forth language currently found in SSR 85-15.

19 This section reflects a similar section in the childhood disability regulations. See 20 C.F.R. § 416.924a(b)(5)(ii).

attempt to obtain adequate descriptive information from all sources that have treated you in the time period relevant to the determination or decision.[20]

54 *Effects of medication.* ~~We must give attention to the effects of medication on your symptoms, signs, and ability to function. While drugs used to modify psychological functions and mental states may control certain primary manifestations of a mental disorder, e.g., hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may not affect all functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the use of such drugs, particular attention must be focused on the functional limitations that may persist.~~ We will consider the effects of medication on your symptoms, signs, laboratory findings, and functioning. Although medications may control the most obvious manifestations of your impairment(s), they may or may not affect the functional limitations imposed by your impairment(s). If your symptoms or signs are reduced by medications, we will consider:

(A) Any of your functional limitations that may nevertheless persist, even if there is improvement from the medications;

(B) Whether your medications create any side effects that cause or contribute to your functional limitations;

(C) The frequency of your need for medication;

(D) Changes in your medication or the way your medication is prescribed; and

(E) Any evidence over time of how medication helps or does not help you control functional limitations caused by your medically determinable impairment or combination of medically determinable impairments.[21]

We will consider these functional limitations in assessing the severity of your impairment. See, e.g., the paragraph C criteria in 12.02, 12.03, 12.04, and 12.06.

Medications used in the treatment of some mental illnesses may cause drowsiness, blunted effect, or other side effects involving other body systems. We will consider such side effects when we evaluate the overall severity of your impairment. Where adverse effects of medications contribute to the impairment severity and the impairment(s) neither meets nor is equivalent in severity to any listing but is nonetheless severe, we will consider such adverse effects in the RFC assessment.

6. *Effects of treatment.* With adequate treatment some individuals with chronic mental disorders not only have their symptoms and signs ameliorated, but they also return to a level of function close to the level of function they had before they developed symptoms or signs of their mental disorders. Treatment may or may not assist in the achievement of

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20 This new section expands on a sentence in current section 12.00E and adds more expansive language from the childhood standard in 20 C.F.R. 416.924a.

21 This language is modeled upon 20 C.F.R. § 416.924a(b)(9).

a level of adaptation adequate to perform sustained SGA. See, e.g., the paragraph C criteria in 12.02, 12.03, 12.04, and 12.06.

G. *Documentation.* The evaluation of disability on the basis of a mental disorder requires sufficient evidence to (1) establish the presence of a medically determinable mental impairment(s), (2) assess the degree of functional limitation the impairment(s) imposes, and (3) project the probable duration of the impairment(s). See §§404.1512 and 416.912 for a discussion of what we mean by "evidence" and how we will assist you in developing your claim. Medical evidence must be sufficiently complete and detailed as to symptoms, signs, and laboratory findings to permit an independent determination. In addition, we will consider information you provide from other sources when we determine how the established impairment(s) affects your ability to function. We will consider all relevant evidence in your case record.

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1. *Sources of evidence.*

a. *Medical evidence.* There must be evidence from an acceptable medical source showing that you have a medically determinable mental impairment. See §§404.1508, 404.1513, 416.908, and 416.913. We will make every reasonable effort to obtain all relevant and available medical evidence about your mental impairment(s), including its history, and any records of mental status examinations, psychological testing, and hospitalizations and treatment. Whenever possible, and appropriate, medical source evidence should reflect the medical source's considerations of information from you and other concerned persons who are aware of your activities of daily living; social functioning; concentration, persistence, or pace; or episodes of decompensation. Also, in accordance with standard clinical practice, any medical source assessment of your mental functioning should take into account any sensory, motor, or communication abnormalities, as well as your cultural and ethnic background.

b. *Information from the individual.* Individuals with mental impairments can often provide accurate descriptions of their limitations. The presence of a mental impairment does not rule you out as a reliable source of information about your own functional limitations. When you have a mental impairment and are willing and able to describe your limitations, we will obtain such information from you. However, you may not be able to fully or accurately describe the limitations resulting from your impairment(s). Sometimes, because of the nature of your impairment, you may be unable to describe your limitations, or you may not want to share information about yourself, or you may describe your functioning in a way that discounts some or all of your limitations. To get a fair and accurate description of how you function, it may be necessary to request information from someone who knows you well and can describe how you usually function on a regular basis. For persons with some kinds of mental impairments (including, but not limited to, TBI, mental retardation, obsessive compulsive disorder, personality disorders, organic mental disorders) it may be necessary for a reliable third party to provide information about functioning.

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~~Thus, w~~We will carefully examine the statements you provide to determine if they are consistent with the information about, or general pattern of, the impairment as described by the medical and other evidence, and to determine whether additional information about your functioning is needed from you or other sources. When this information will be helpful to a fair determination of disability, you may provide information about your functioning from a third party yourself, or we may request additional information from someone who knows you and how you function on a day to day basis. We are most likely to request information from a third party who knows you well if you have difficulty describing your impairment, your symptoms, your limitations, or your day to day functioning in a manner that is consistent with the medical and other evidence you have provided. We will not draw any inference from the lack of third-party support should this be unavailable or inaccessible to us.

c. *Other information.* Other sources may include many of the primary sources of treatment for individuals with mental impairments, e.g., nurse practitioners and physician's assistants, therapists, psychiatric social workers, mental health workers, and educational or rehabilitation personnel. Many individuals with mental impairments are seen infrequently by physicians or psychiatrists and usually only interact with these medical sources for a review of medications. Other professionals are qualified and trained to recognize, and treat, mental impairments and often are the most important source of evidence about individuals with mental impairments. Nonphysician sources (e.g., therapists, social workers, counselors) may interact with the claimant more frequently than a treating psychiatrist and may have a more thorough knowledge of the limitations caused by the claimant's impairments. ~~Other professional health care providers (e.g., psychiatric nurse, psychiatric social worker) can normally provide valuable functional information, which should be obtained when available and needed.~~

If necessary, information should also be obtained from nonmedical sources, such as family members and others who know you, to supplement the record of your functioning in order to establish the consistency of the medical evidence and longitudinality of impairment severity, as discussed in 12.00D2. Other sources of information about functioning include, but are not limited to, records from work evaluations, ~~and~~ rehabilitation progress notes, and, for younger adults, records from school, school-related activities, and vocational education programs.[22]

2. *Need for longitudinal evidence.* Many mental impairments are episodic in nature and the effectiveness of treatment many vary over time. Your level of functioning may vary considerably over time. The level of your functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of your impairment(s) must take into account any variations in the level of your functioning in arriving at a determination of severity over time. Thus, it is vital to obtain evidence from relevant

22 This language is added to remind decisionmakers that, in assessing younger adults, school and vocational education evidence is important and should be obtained and reviewed.

sources over a sufficiently long period prior to the date of adjudication to establish your impairment severity.

3. *Work and work attempts.* You may be working now. You may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work or it may have been in conjunction with a community mental health or sheltered program or in a supported work program, and it may have been of either short or long duration. Information concerning your behavior and how you functioned during any attempt to work and the circumstances surrounding termination of your work effort are particularly useful in determining your ability or inability to function in a work setting. In addition, we should also examine the degree to which you require special supports (such as those provided through supported employment or transitional employment programs) in order to work. The criteria set forth in 20 C.F.R. §§ 404.1572—404.1576 and 416.972—416.976 will be used to evaluate your ability to sustain independent and effective function in a work setting.

4. *School attendance and vocational training.* If you are a younger adult, you may have recently attended school or you may still be attending school. You may also have participated or are participating in vocational education. Information concerning your behavior during attendance and the circumstances surrounding your attendance at school or vocational education, including but not limited to, special education services you received or accommodations provided because of your impairment(s) is particularly useful in determining your ability to function in a work setting.[23]

45. *Mental status examination.* The mental status examination is performed in the course of a clinical interview and is often partly assessed while the history is being obtained. A comprehensive mental status examination generally includes a narrative description of your appearance, behavior, and speech; thought process (*e.g.*, loosening of associations); thought content (*e.g.*, delusions); perceptual abnormalities (*e.g.*, hallucinations); mood and affect (*e.g.*, depression, mania); sensorium and cognition (*e.g.*, orientation, recall, memory, concentration, fund of information, and intelligence); and judgment and insight. The individual case facts determine the specific areas of mental status that need to be emphasized during the examination.

~~5~~6. *Psychological testing.*

a. Reference to a "standardized psychological test" indicates the use of a psychological test measure that has appropriate validity, reliability, and norms, and is individually administered by a qualified specialist. By "qualified," we mean the specialist must be

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23 This new section makes clear the importance of education and vocational education records, particularly records concerning special education and accommodations, in evaluating mental disability for younger adults. The language paraphrases language discussing school records in the childhood disability regulations. See 20 C.F.R. § 416.924a(a)(2)(iii).

currently licensed or certified in the State to administer, score, and interpret psychological tests and have the training and experience to perform the test.

b. Psychological tests are best considered as standardized sets of tasks or questions designed to elicit a range of responses. Psychological testing can also provide other useful data, such as the specialist's observations regarding your ability to sustain attention and concentration, relate appropriately to the specialist, and perform tasks independently (without prompts or reminders). Therefore, a report of test results should include both the objective data and any clinical observations.

c. The salient characteristics of a good test are: (1) Validity, *i.e.*, the test measures what it is supposed to measure; (2) reliability, *i.e.*, the consistency of results obtained over time with the same test and the same individual; (3) appropriate normative data, *i.e.*, individual test scores can be compared to test data from other individuals or groups of a similar nature, representative of that population; and (4) wide scope of measurement, *i.e.*, the test should measure a broad range of facets/aspects of the domain being assessed. In considering the validity of a test result, we should note and resolve any discrepancies between formal test results and the individual's customary behavior and daily activities, and be sensitive to the cultural and ethnic background of the individual.

~~6~~7. *Intelligence tests.*

a. The results of standardized intelligence tests may provide data that help verify the presence of mental retardation or organic mental disorder, as well as the extent of any compromise in cognitive functioning. However, since the results of intelligence tests are only part of the overall assessment, the narrative report that accompanies the test results should comment on whether the IQ scores are considered valid and consistent with the developmental history and the degree of functional limitation.

b. Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not covered under the provisions of 12.05A. Listing 12.05A may be the basis for adjudicating cases where the results of standardized intelligence tests are unavailable, *e.g.*, where your condition precludes formal standardized testing.

c. Due to such factors as differing means and standard deviations, identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. The IQ scores in 12.05 reflect values from tests of general intelligence that have a mean of 100 and a standard deviation of 15; *e.g.*, the Wechsler series. IQs obtained from standardized tests that deviate from a mean of 100 and a standard deviation of 15 require conversion to a percentile rank so that we can determine the actual degree of limitation reflected by the IQ scores. In cases where more than one IQ is customarily derived from the test administered, *e.g.*, where verbal, performance, and full scale IQs are provided in the Wechsler series, we use the lowest of these in conjunction with 12.05

d. Generally, it is preferable to use IQ measures that are wide in scope and include items that test both verbal and performance abilities. However, in special circumstances, such as the assessment of individuals with sensory, motor, or communication abnormalities, or those whose culture and background are not principally English-speaking, measures such as the Test of Nonverbal Intelligence, Third Edition (TONI-3), Leiter International Performance Scale-Revised (Leiter-R), or Peabody Picture Vocabulary Test—Third Edition (PPVT-III) may be used.

e. We may consider exceptions to formal standardized psychological testing when an individual qualified by training and experience to perform such an evaluation is not available, or in cases where appropriate standardized measures for your social, linguistic, and cultural background are not available. In these cases, the best indicator of severity is often the level of adaptive functioning and how you perform activities of daily living and social functioning.

87. *Personality measures and projective testing techniques.* Results from standardized personality measures, such as the Minnesota Multiphasic Personality Inventory-Revised (MMPI-II), or from projective types of techniques, such as the Rorschach and the Thematic Apperception Test (TAT), may provide useful data for evaluating several types of mental disorders. Such test results may be useful for disability evaluation when corroborated by other evidence, including results from other psychological tests and information obtained in the course of the clinical evaluation, from treating and other medical sources, other professional health care providers, and nonmedical sources. Any inconsistency between test results and clinical history and observation should be explained in the narrative description.

98. *Neuropsychological assessments.* Comprehensive neuropsychological examinations may be used to establish the existence and extent of compromise of brain function, particularly in cases involving organic mental disorders. Normally, these examinations include assessment of cerebral dominance, basic sensation and perception, motor speed and coordination, attention and concentration, visual-motor function, memory across verbal and visual modalities, receptive and expressive speech, higher-order linguistic operations, problem-solving, abstraction ability, and general intelligence. In addition, there should be a clinical interview geared toward evaluating pathological features known to occur frequently in neurological disease and trauma, *e.g.*, emotional lability, abnormality of mood, impaired impulse control, passivity and apathy, or inappropriate social behavior. The specialist performing the examination may administer one of the commercially available comprehensive neuropsychological batteries, such as the Luria-Nebraska or the Halstead-Reitan, or a battery of tests selected as relevant to the suspected brain dysfunction. The specialist performing the examination must be properly trained in this area of neuroscience.

910. *Screening tests.* In conjunction with clinical examinations, sources may report the results of screening tests; *i.e.*, tests used for gross determination of level of functioning. Screening instruments may be useful in uncovering potentially serious impairments, but often must be supplemented by other data. However, in some cases the results of

screening tests may show such obvious abnormalities that further testing will clearly be unnecessary.

101. *Traumatic brain injury (TBI).* In cases involving TBI, follow the documentation and evaluation guidelines in 11.00F.

112. *Anxiety disorders.* In cases involving agoraphobia and other phobic disorders, panic disorders, and posttraumatic stress disorders, documentation of the anxiety reaction is essential. At least one detailed description of your typical reaction is required. The description should include the nature, frequency, and duration of any panic attacks or other reactions, the precipitating and exacerbating factors, and the functional effects. If the description is provided by a medical source, the reporting physician or psychologist should indicate the extent to which the description reflects his or her own observations and the source of any ancillary information. Statements of other persons who have observed you may be used for this description if professional observation is not available.

We have added criteria for evaluating the severity of post-traumatic stress disorders (PTSD) to Listing 12.06. There may be varied origins for the anxiety associated with PTSD, which may include a single traumatic event or recurring events of physical or emotional distress that result in the symptoms associated with PTSD (e.g., child abuse, spouse abuse, or neglect situations). Therefore, we will consider current level of severity of your impairment without making any judgment about the origin of your anxiety symptoms.

132. *Eating disorders.* In cases involving anorexia nervosa and other eating disorders, the primary manifestations may be mental or physical, depending upon the nature and extent of the disorder. When the primary functional limitation is physical, *e.g.*, when severe weight loss and associated clinical findings are the chief cause of inability to work, we may evaluate the impairment under the appropriate physical body system listing. Of course, we must also consider any mental aspects of the impairment, unless we can make a fully favorable determination or decision based on the physical impairment(s) alone. We have outlined specific criteria for evaluating the severity of eating disorders (e.g., bulimia, anorexia) in Listing 12.xx

HE. ~~*Chronic mental impairments.* Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. For instance, if you have chronic organic, psychotic, and affective disorders, you may commonly have your life structured in such a way as to minimize your stress and reduce your symptoms and signs. In such a case, you may be much more impaired for work than your symptoms and signs would indicate. The results of a single examination may not adequately describe your sustained ability to function. It is, therefore, vital that we review all pertinent information relative to your condition, especially at times of increased stress. We will attempt to obtain adequate descriptive information from all sources that have treated you in the time period relevant to the determination or decision.~~

F. *Effects of structured settings.* Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, halfway house, board and care facility, or other environment that provides similar structure. Highly structured and supportive settings may also be found in your home. Such settings may greatly reduce the mental demands placed on you. With lowered mental demands, overt symptoms and signs of the underlying mental disorder may be minimized. At the same time, however, your ability to function outside of such a structured or supportive setting may not have changed. If your symptomatology is controlled or attenuated by psychosocial factors, we must consider your ability to function outside of such highly structured settings. For these reasons, identical paragraph C criteria are included in 12.02, 12.03, and 12.04. The paragraph C criterion of 12.06 reflects the uniqueness of agoraphobia, an anxiety disorder manifested by an overwhelming fear of leaving the home.

G. *Effects of medication.* We must give attention to the effects of medication on your symptoms, signs, and ability to function. While drugs used to modify psychological functions and mental states may control certain primary manifestations of a mental disorder, *e.g.*, hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may not affect all functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the use of such drugs, particular attention must be focused on the functional limitations that may persist. We will consider these functional limitations in assessing the severity of your impairment. See the paragraph C criteria in 12.02, 12.03, 12.04, and 12.06.

Drugs used in the treatment of some mental illnesses may cause drowsiness, blunted effect, or other side effects involving other body systems. We will consider such side effects when we evaluate the overall severity of your impairment. Where adverse effects of medications contribute to the impairment severity and the impairment(s) neither meets nor is equivalent in severity to any listing but is nonetheless severe, we will consider such adverse effects in the RFC assessment.

H. *Effects of treatment.* With adequate treatment some individuals with chronic mental disorders not only have their symptoms and signs ameliorated, but they also return to a level of function close to the level of function they had before they developed symptoms or signs of their mental disorders. Treatment may or may not assist in the achievement of a level of adaptation adequate to perform sustained SGA. See the paragraph C criteria in 12.02, 12.03, 12.04, and 12.06.

I. *Technique for reviewing evidence in mental disorders claims to determine the level of impairment severity.* We have developed a special technique to ensure that we obtain, consider, and properly evaluate all the evidence we need to evaluate impairment severity in claims involving mental impairment(s). We explain this technique in §§404.1520a and 416.920a.